JCSM
Journal of Clinical Sleep Medicine

EDITORIAL

"If I were AASM President I would…"

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I HAVE BEEN AN ACTIVE AASM MEMBER SINCE 1989 AND IN THE 18 YEARS THAT FOLLOWED I'VE OFTEN MUSED "IF I WERE AASM PRESIDENT I WOULD…". I'M confident that many reading this editorial have thought similarly. By my admittedly crude estimation, if I had a dollar for each time I thought or spoke these words, I'd be closer to retirement. In my four years of service on your Board of Directors I began to focus what was before a loosely associated group of individual beliefs and ideas into a vision for the future of sleep medicine. The amalgamation occurred neither in a vacuum nor by happenstance. Rather, it was forged from my collective experience as a physician-scientist, sleep fellowship program director, sleep center administrator, and entrepreneur coupled with counsel from your past Presidents, your Board of Directors, and the institutional memory and pragmatism of your executive staff. Unless stipulated otherwise, the opinions offered in this editorial should be viewed as personal and may not necessarily reflect AASM policy. In the lines that follow I will fill in the "…" of the phrase "If I were AASM President I would…" with intent to highlight select areas of personal interest.

Sleep medicine is an independent medical subspecialty having earned formal recognition and endorsement from the medical community. In November of this year I will be among many of you when we take the first ever American Board of Medical Specialties credentialing exam in sleep medicine. The value of specialty recognition cannot be overemphasized, and we must not expect growth of the field without activism from vested individual practitioners, researchers, and their respective professional organizations. In my 18 years as Chief of the Sleep Medicine fellowship program at Mount Sinai Medical Center in Miami Beach I have graduated 22 physician Diplomates of the American Board of Sleep Medicine, the vast majority of whom desire a fulltime practice in sleep medicine. However, thus far only 3 have succeeded because, in part, practitioners lacking sleep training benefit from a system that unintentionally fails to reward specialty expertise in sleep medicine. It is incumbent on us to position sleep medicine such that the added time and expense of training are rewarded by more than another certificate on the office wall. Lacking a secure future in sleep medicine, our most gifted scientists and clinicians will justifiably seek alternate career tracts. As the professional association that represents sleep medicine, the AASM must capitalize its resources to highlight the unique expertise and value of the credentialed expert in sleep medicine. If sleep medicine is to grow, I believe we need to create a fundamental shift in both fiscal policy and entrained behavior.

Clearly I am not the first AASM President intent on raising professional and public awareness of sleep disorders and of sleep medicine specialists. However, I see this as a pivotal time in the evolution of sleep medicine with opportunities for substantial gains that were not available to those that preceded me. Fortuitously, my term coincides with three major occurrences that can be exploited toward this goal. First, the inaugural ABMS Sleep certification exam raises the profile of the sleep specialist credential; second, other than the war in Iraq, health care reform dominates presidential elections politics and debates; and third, the April 2006 release of the Institute of Medicine report, Sleep Deprivation and Sleep Disorders: An Unmet Public Health Problem[1] heightened public and professional awareness about the importance of sleep in health and disease. While individually important, collectively, these events raise awareness of healthcare issues in general and sleep health care in particular to an unprecedented level.

The AASM is intent on providing the highest quality care and ensuring the health and well-being of patients with sleep disorders. Sleep Center and Sleep and Breathing Laboratory accreditation by the AASM was established in 1977 specifically to maintain standards for the evaluation and treatment of sleep disorders.[2] As early as 1989 AASM leadership recognized that quality sleep healthcare mandated the development of clinical practice parameters and guidelines derived from rigorous scientific evidence, and in response created the Standards of Practice Committee. Ever since the first AASM Standards of Practice Publication in 1992, the Academy has relied on practice parameters derived from these evidence-based Standards of Practice publications as the cornerstone of clinical practice and facility accreditation. The findings by Parthasarathy and colleagues[2] that sleep apnea patients managed by a sleep specialist and tested in an AASM accredited center are more likely to continue positive airway pressure (PAP) therapy, use PAP for more hours per night, and profess greater satisfaction with care than those receiving care by physicians without credentials in sleep medicine at nonaccredited facilities serves as testament to the value of AASM accreditation and specialty care for patients with sleep disorders. The notion that specialist care improves outcome is not unique to sleep medicine, as intensivists, cardiologists, and some surgical specialists have demonstrated similar benefit in outcome when care is delivered

by the respective specialist. Further evidence that specialty care provided through disorder specific accredited facilities improves patient outcomes has been documented for bariatric surgery and served to justify the Center for Medical Services national coverage determination policy for bariatric surgical procedures; these procedures are reimbursed only when performed at a facility that is certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center or certified by the American Society for Bariatric Surgery as a Bariatric Surgery Center of Excellence.[3] That evaluation and treatment by specialists in accredited facilities improves patient outcomes is no longer a matter of debate. Therefore, "If I were AASM President I would" lobby public and private payers to link reimbursement for sleep related health services to facilities accredited by the AASM.

Convincing private and public payers of the value of linking reimbursement for sleep services to AASM accredited facilities requires sensitivity to the geographic distribution of AASM accredited facilities, consideration of fiscal implications for new and existing facilities, and willingness to embrace innovative healthcare paradigms and advancements in health information technology. This includes the incorporation into sleep medicine practice chronic healthcare models adapted to suit the unique needs of our patients and capabilities of our facilities. By partnering with other specialties and allied health educators, chronic care models provide sleep medicine with the opportunity to introduce the benefits of healthy sleep on a wide variety of medical and mental health disorders. Therefore, "if I were AASM President I would" begin to fashion chronic care models for specific sleep disorders and encourage incorporation of healthy sleep practices into existing chronic care models for disorders where sleep loss is known to adversely effect outcome. In so doing we can simultaneously improve patient care and raise the value of our field.

The number of AASM accredited facilities continues to grow, and AASM accreditation-reimbursement linkage must not impede the creation of new centers and laboratories. By delaying payment for services rendered until accredited, AASM accreditation-reimbursement linkage could unintentionally discourage the creation of new sleep centers and harm existing centers not accredited by the AASM. In preparation for adoption of AASM accreditation-reimbursement linkage, AASM leadership developed Provisional Accreditation, a program designed to expedite accreditation of new sleep disorders facilities and obviate any delay in reimbursement consequent to accreditation-reimbursement linkage. This program also serves to encourage accreditation of existing sleep facilities in geographic areas where AASM accredited sleep facilities are either lacking or underrepresented.

The United States Department of Health and Human Services promotes a system for American healthcare that it has termed "Value Driven Healthcare" (VDH).[5] The model envisioned aims for health care transparency to provide consumers with the information and the incentive to choose health care providers based on value. The four major components of VDH include health information technology, quality standards, price standards, and incentives. If adopted, solo practitioners and physician groups will be at a competitive disadvantage unless they adopt systems that allow for cost and outcome transparency. At minimum, this translates into an electronic medical record or preferably an interoperable electronic health record. The widespread use of health information technology is inevitable; the question is when to invest and how to leverage health information technology to provide the highest quality care for our patients with sleep disorders. Therefore, "if I were AASM President I would" investigate mechanisms that capitalize on electronic health informatics to promote quality sleep healthcare and support the independent practice of sleep medicine.

The nature of an editorial limits me from providing thoughtful dialogue on other matters salient to the future of sleep medicine. Nonetheless, the topics presented in this editorial represent areas of most overlap between the current healthcare environment and my unique skills. As the year unfolds, I am hopeful that I will be allowed to provide my insight in other areas relevant to sleep practitioners, researchers, behavioral specialists, technologists, and allied health personnel.

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